ATTACH CHECK HERE

GEORGIA MEDICAL BOARD (GMB) USE ONLY

AP NUMBER	_____	**FILE NUMBER**	_____
RECEIVED	_____	**COMPLETED**	_____
TEMP LICE NO	_____	**DATE ISSUED**	_____
LICENSE NUMBER	_____	**DATE ISSUED**	_____
WITHDRAWN	_____	**DATE WITHDRAWN**	_____
DENIED	_____	**DATE DENIED**	_____

* **EFFECTIVE JULY 1, 2001 ALL FEES ARE NONREFUNDABLE***

F E E S A R E S U B J E C T T O C H A N G E

Please check one of the boxes below:

☐ **Yes, I will be using the Federation Credentials Verification Service (FCVS)**

☐ **No, I will not be using the Federation Credentials Verification Service (FCVS)**

BASIC INFORMATION

1. US Social Security Number: _____ _____ _____ - _____ _____ - _____ _____ _____ _____

This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A. § 19-11-1 and O.C.G.A. § 20-3-295, 42 U.S.C.A. § 651 and 20 U.S.C.A. § 1001. This information also may be disclosed to the National Practitioner's Data Bank (NPDB) or other state medical boards or regulatory agencies for license tracking purposes.

❑ **I do <u>not</u> wish this information to be released to the NPDB, other medical boards, or other regulatory agencies for license tracking purposes.**

2. LAST NAME	FIRST NAME	MIDDLE NAME	DEGREE (MD OR DO)

MAIDEN NAME	SEX M F	DATE OF BIRTH (MM/DD/YY)	NAME OF MEDICAL SCHOOL

3. Mailing address – This address will be used to mail application status information.			
STREET NUMBER STREET NAME			APARTMENT #
CITY	STATE	ZIP CODE	COUNTY
( )	( )		@
(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER (OPTIONAL)		E-MAIL ADDRESS

4. Practice street address – This address will appear on the internet.			
STREET NUMBER STREET NAME			SUITE #
CITY	STATE	ZIP CODE	COUNTY
( )	( )		
(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER (OPTIONAL)		

BASIC INFORMATION (Continued)

5. What examinations have you taken?

❑ COMLEX	❑ USMLE ❑ NBME	❑ NBOME ❑ LMCC	❑ FLEX ❑ STATE BOARD	STATE

6. How long have you lived in the US? _____YEARS _____MONTHS

7. Have you served in the armed forces? ❑ Yes ❑ No ❑ Not applicable	DATES OF SERVICE (MM/DD/YY – MM/DD/YY) _____
8. Have you been discharged? ❑ Yes ❑ No ❑ Not applicable	DATE OF DISCHARGE (MM/DD/YY) _____ TYPE OF DISCHARGE _____

BOARD CERTIFICATION INFORMATION

9. Are you Board Certified in your medical specialty? Provide information on any certification, specialty, or subspecialty from any specialty board regulating the profession for which you are certified.

❑ Yes, I am board certified in the specialty of: _____

❑ No, I am not board certified in my specialty of: _____

❑ I am specialty board-trained in _____
SPECIALTY

❑ I am scheduled to take the ABMS examination on:

DATE

❑ I am scheduled to take the NBOME examination on:

DATE

APPLICANT QUESTIONNAIRE

INSTRUCTIONS: If you answer, "YES" to questions 1-19, you are required to furnish complete details, including date, place, reason and disposition of the matter. Question 20 must be answered even if you do not plan to practice in Georgia. Failure to furnish complete documentation may result in a delay in the processing of your application. I understand that my questionnaire may be selected for verification of the information provided. I recognize that providing false information or incomplete information may result in disciplinary actions against my license pursuant to O.C.G.A. §§ 43-1-19 and 43-34-37 and may result in criminal penalties, up to and including reporting to the NPDB.	**YES**	**NO**
1. Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven years? (Provide the Board with all treatment history documentation to include diagnosis, treatment regimen, medical regimen, hospitalization, and on-going treatment/medication.)	❑	❑
2. Have you ever been arrested for, and/or convicted of, a violation of any Federal (including military), State or Local statute?	❑	❑
3. Have you ever been denied the privilege of taking an examination given by any licensing Board or agency?	❑	❑
4. Has any licensing Board or agency ever denied you a certificate or a license?	❑	❑
5. Has any licensing Board or agency ever refused you renewal of a certificate or a license?	❑	❑
6. Have you ever been denied a DEA registration number?	❑	❑
7. Have you ever been issued a restricted DEA registration?	❑	❑
8. Are you currently registered with the DEA? If you are registered with the DEA, provide the number and state of issue below: DEA Number _____ State of issue_____	❑	❑
9. Have you ever had any malpractice suits filed against you?	❑	❑
10. Have you ever been denied membership in or in any way sanctioned by any medical or osteopathic association, society, or specialty society	❑	❑
11. Have you ever resigned from a hospital staff position or training program after a complaint or peer review action has been initiated against you?	❑	❑
12. Have you ever voluntarily surrendered a medical license?	❑	❑
13. Have you ever voluntarily surrendered a controlled substance registration?	❑	❑
14. Have you ever voluntarily surrendered a DEA registration?	❑	❑
15. To your knowledge, are you the subject of an investigation by any licensing Board or agency as of the date of this application?	❑	❑
16. Do you have any applications for licensure pending before any other licensing Board or agency?	❑	❑
17. Have you ever had any restrictions as a Medicaid or Medicare provider?	❑	❑
18. Are you in default on a state or federally funded and/or guaranteed school loan?	❑	❑
19. Are you in default on child support payments?	❑	❑
20. Do you intend to practice medicine in Georgia? If yes, please provide your practice plans in the space provided:_____ _____	❑	❑
21. Did you include a copy of your CV or résumé with this application packet?	❑	❑

LICENSE HISTORY

<u>INSTRUCTIONS</u>: Original verifications of license history certification is required for each permanent, temporary, training, provisional, or limited license obtained in any state in the US or Canadian territory, Canadian province, or US Federal jurisdiction. The issuing authority should mail the verification to the Medical Board. If licensed by examination, give the state. If licensed by reciprocity, provide the state. Provide the current status of the license: active, inactive, revoked, suspended, probation, limited, etc. You may make copies of this page if more space is needed.

STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	

TRAINING

<u>INSTRUCTIONS</u>: Provide the name of your high school and dates of attendance. For pre-medical education and medical/osteopathic education, indicate all beginning and ending months and years of each of attendance. All gaps in the chronological progression of your training must be explained on a separate piece of paper, i.e., leave of absences, sabbaticals, taking a year off to work in order to pay for the next year of training, etc. <u>Do not group years together</u>, i.e., 1997 – 2001. Each year of attendance must be accounted for, or this section will be returned as incomplete.

PRELIMINARY EDUCATION

NAME OF HIGH SCHOOL ATTENDED	DATES OF ATTENDANCE - MONTH AND YEAR (MM/YY TO MM/YY)

PRE-MEDICAL EDUCATION

NAME OF COLLEGE ATTENDED	DATES OF ATTENDANCE – MONTH AND YEAR (MM/YY TO MM/YY) 1ST YEAR
	2ND YEAR
	3RD YEAR
	4TH YEAR

MEDICAL/OSTEPATHIC EDUCATION

NAME OF MEDICAL SCHOOL ATTENDED	DATES OF ATTENDANCE – MONTH AND YEAR (MM/YY TO MM/YY) 1ST YEAR
	2ND YEAR
	3RD YEAR
	4TH YEAR

If you attended more than four years of medical school, continue below:

	5th YEAR
	6th YEAR

POSTGRADUATE TRAINING: Provide listing of hospitals where postgraduate training has been completed or ongoing and specialty.

Specialty	Hospital/State
Specialty	Hospital/State
Specialty	Hospital/State

Attach additional sheets if necessary.

USA AND INTERNATIONAL GRADUATES – HOSPITAL PRIVILEGES
<u>INSTRUCTIONS</u>: ALL applicants must complete this section. If you had no hospital privileges indicate this and list the hospital(s) where you did your internship/residency. List all hospitals where you held any type of privileges, include addresses. Copy this page if more space is needed to list hospitals where privileges were held.
❑ Not applicable, I have not held any hospital privileges. ❑ Not applicable. My internship/residency was done at the following hospital:
HOSPITAL
ADDRESS
❑ Yes, I have held privileges at the following hospital:
HOSPITAL
ADDRESS
❑ Yes, I have held privileges at the following hospital:
HOSPITAL
ADDRESS
❑ Yes, I have held privileges at the following hospital:
HOSPITAL
ADDRESS
❑ Yes, I have held privileges at the following hospital:
HOSPITAL
ADDRESS
Copy this page if more space is needed to complete the list of hospital privileges.

AFFIDAVIT OF APPLICANT

TOP OF PHOTO (HEAD)

Paste or Staple a 2 ¼ x 3 inch photo here.

Photo must be of your Head and Shoulder Area only.

BOTTOM OF PHOTO (SHOULDERS)

Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Georgia Law that authorizes collection of this information. The information on your application may be transferred to other medical licensing authorities the Federation of State Medical Boards or other governmental or law enforcement agencies.

I acknowledge and state that I have read the Application for Physician Licensure Information and Applicant instructions that accompanied this application and I have answered all questions in compliance with these instructions. I acknowledge that it is my responsibility to read and become familiar with the Medical Practice Act and the Board Rules, copies of which are sent to applicants.

I further state that by filing this application for license to practice medicine in the State of Georgia; I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. I agree to give any further information, which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its content and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board or Court Order.
I request and authorize any treatment program to release alcohol and drug abuse patient records to the Composite State Board of Medical Examiners for the purpose of evaluating my fitness to practice. The consent of this paragraph is subject to revocation pursuant to federal regulations and terminates upon the date of termination of medical licensure in Georgia.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or International), court, association, institution, or other organization having control of my documents, records and other information pertaining to me, to furnish to the Georgia Composite State Board of Medical Examiners any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Georgia Composite State Board of Medical Examiners or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice there under.

I authorize and request the Georgia Composite State Board of Medical Examiners to obtain any criminal history information concerning me from any authorized law enforcement agency, including but not limited to the Georgia Crime Information Center (GCIC) and the National Crime Information Center (NCIC).

I hereby release, discharge, and exonerate the Georgia Composite State Board of Medical Examiners, its agents or representatives, and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Composite State Board of Medical Examiners.

This is to certify that the forgoing information is true and correct to the best of my knowledge. I understand that pursuant to the Official Code of Georgia Annotated, Section 43-34-46, any person who shall give false or forged evidence of any kind to the Board in connection with an application for a license to practice medicine shall be guilty of a felony and upon conviction thereof, shall be punished by a fine of not less than $500.00 nor more than $1,000.00, or by imprisonment from two to five years, or both.

Printed Name of Applicant: _____ Date: _____

Signature of Applicant: _____

Being duly sworn, says that he/she is the person who executed the application for a license to practice medicine and surgery in the State of Georgia; that all the statements herein contained are true in every respect; and that the attached photo is a true photo of the applicant.

Affix the Notary Seal/Stamp In this space.

Sworn and subscribed to me this ____ day of _____ in the year _____.

Signature of Public Notary: _____

My Commission Expires: _____